North (Region 1)
RTCC

David Shatz, MD – Chair

Karen Crain-Riddle, RN - Administrator

Regional Trauma Coordinating Committees

Region I - North
Coastal Valleys EMS Agency
El Dorado County EMS Agency
Napa EMS Agency
NorCal EMS Agency
North Coast EMS Agency
Sacramento County EMS Agency
San Joaquin County EMS Agency
Sierra-Sacramento EMS
Yolo EMS Agency Agency

Region II - Bay Area
Alameda County EMS Agency
Contra Costa County EMS Agency
Marin County EMS Agency
Monterey County EMS Agency
San Benito County EMS Agency
Solano County EMS Agency
San Francisco County EMS Agency
San Mateo County EMS Agency
Santa Clara County EMS Agency
Santa Cruz County EMS Agency

Region III - Central
Central California EMS Agency
Kern County EMS Agency
Merced County EMS Agency
Mountain Valley EMS Agency
Tuolumne County EMS Agency

Region IV – South-West
Los Angeles County EMS Agency
Orange County EMS Agency
San Luis Obispo County EMS Agency
Santa Barbara County EMS Agency
Ventura County EMS Agency

Region V – South-Eastern
Imperial County EMS Agency
Inland Counties EMS Agency
Riverside County EMS Agency
San Diego County EMS Agency

North RTCC

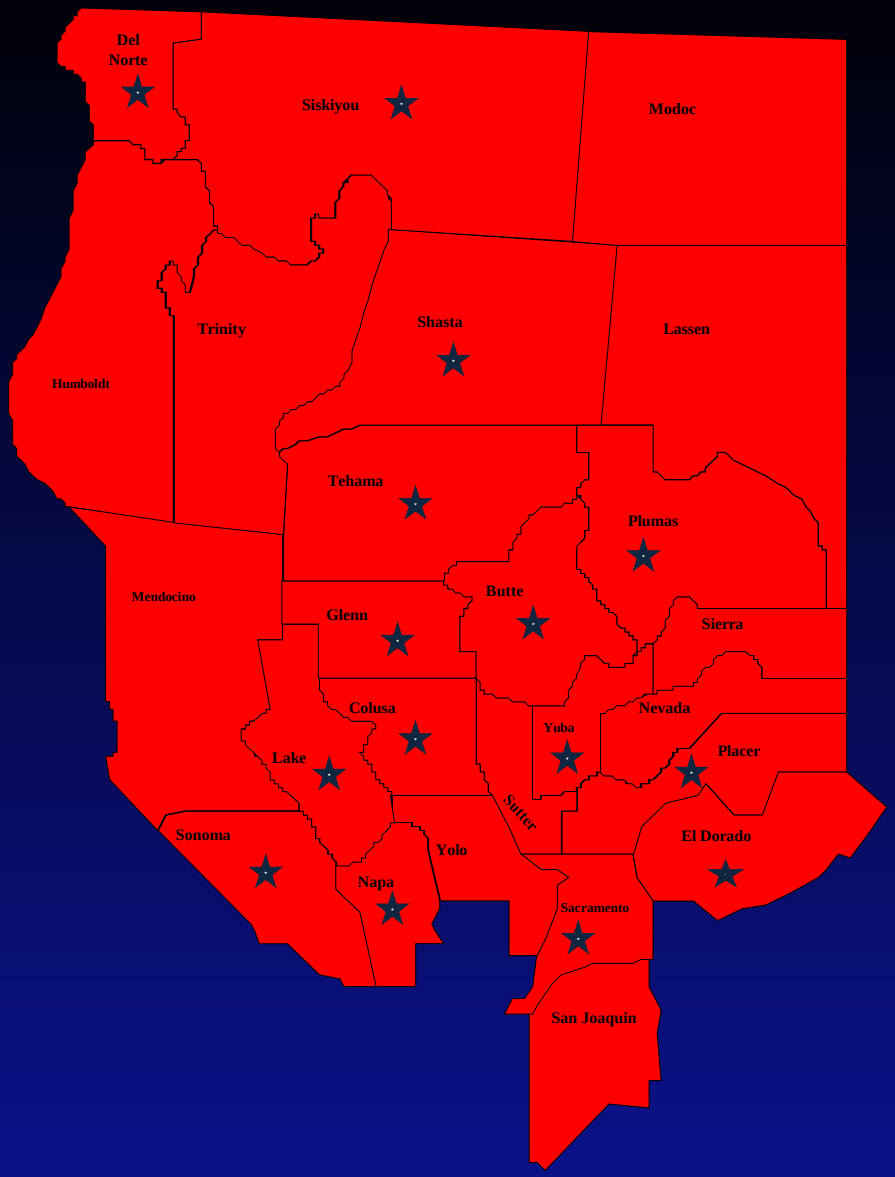
4,676,171 Population
51,203 Square miles
Population density: 82

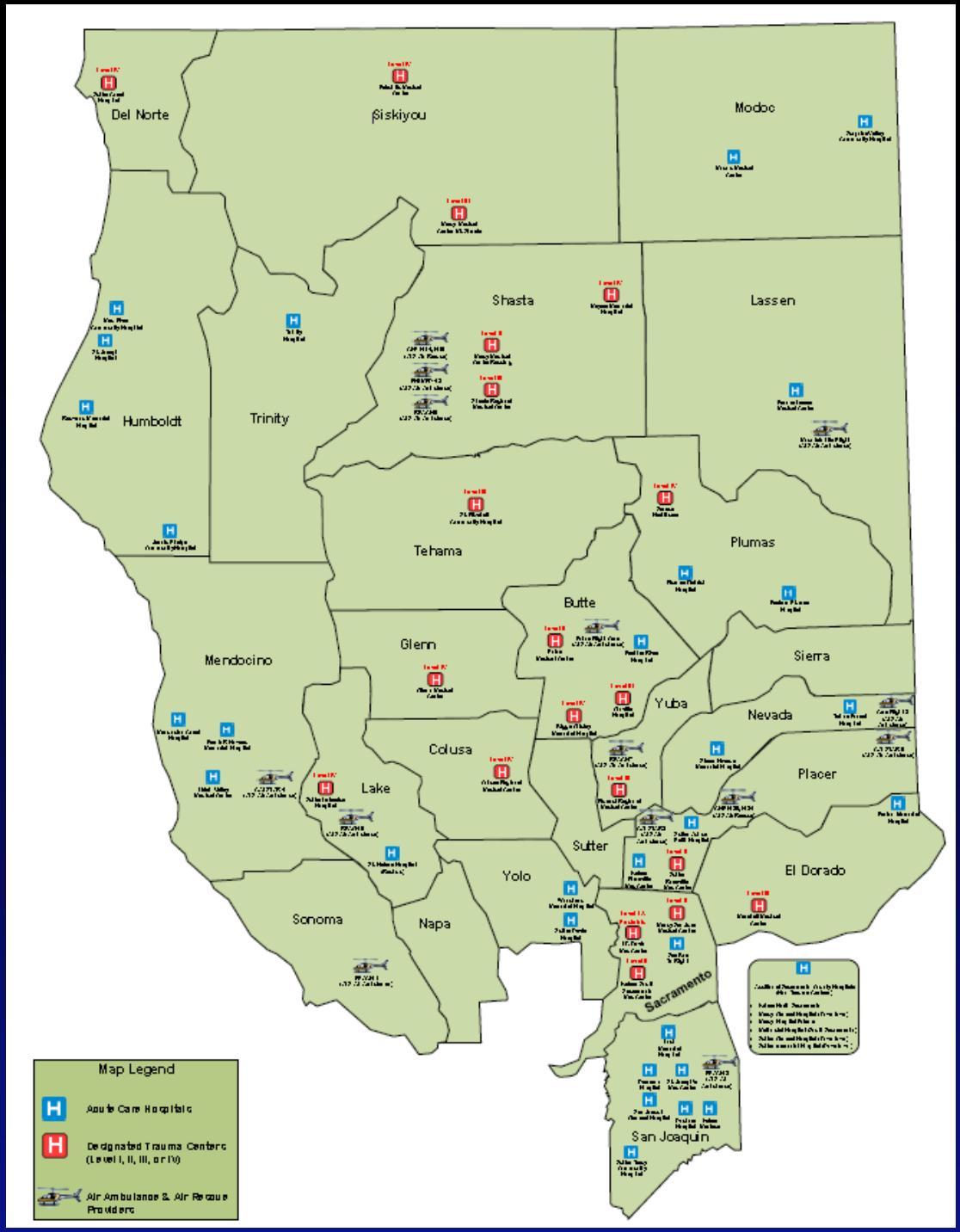
25 Counties

77 Hospitals (GAH)
64 Emergency Dept.
20 Critical Access
9,745 Licensed Beds*

9 LEMSAs

1 Level I TC
1 Level I Peds TC
6 Level II TCs
7 Level III TCs
8 Level IV TCs




Del Norte
Siskiyou
Modoc
Humboldt
Trinity
Shasta
Lassen
Tehama
Plumas
Butte
Glenn
Mendocino
Sierra
Yuba
Nevada
Colusa
Lake
Placer
Sutter
Yolo
El Dorado
Sonoma
Napa
Sacramento
San Joaquin
Map Legend
Acute Care Hospitals
Designated Trauma Centers (Level I, II, III, or IV)
Air Ambulance & Air Rescue Providers

Meeting Format

- 10 AM – Announcements, updates, etc.
- 11 AM – CE topic
- 12 PM – Lunch
- 1 PM – Committee meetings
- 2 PM – Committee reports
- 2:30 PM – Wrap-up, future meetings
- 3 PM - Adjourn

Committees

- Data
- Verification
- Interfacility transfer/repatriation
- Prehospital

NORTH REGIONAL TRAUMA COMMITTEE

Suggested Criteria for Consideration of Transfer to a Trauma Center

EMERGENCY TRAUMA TRANSFER: Call the Trauma Center for immediate consult and/or acceptance. **Avoid unnecessary studies that would delay the transfer.** The goal is to transfer the patient within one hour of arrival or less.

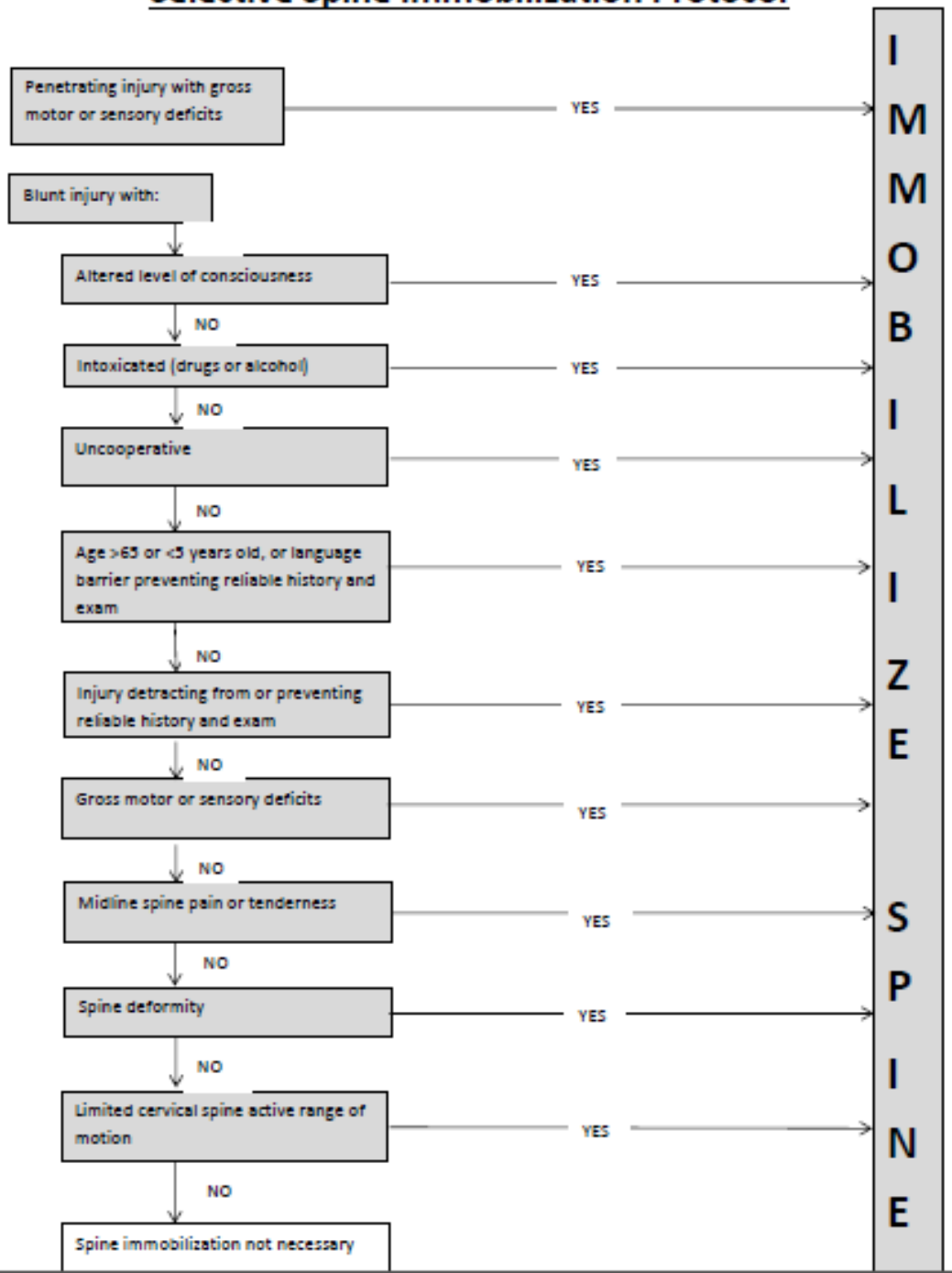
Note: All transfers must be in accordance with both state and federal EMTALA laws.

PHYSIOLOGIC	CO-MORBID FACTORS
♦ Systolic blood pressure less than 90 mmHg. ♦ Labile blood pressure despite two liters of intravenous of crystalloids. ♦ For a child, labile blood pressure despite 20 mls/kg of fluid resuscitation. ♦ Patient requiring blood products to maintain their blood pressure.	♦ Adults greater than 55 years of age with significant trauma. ♦ Significant torso injury with advanced co-morbid disease (cardiac or respiratory disease, insulin-dependent diabetes, morbid obesity, immunosuppression or End Stage Renal Disease requiring dialysis). ♦ Patient taking anti-coagulant medication or platelet inhibitors. ♦ Children less than 14 years of age with significant trauma. ♦ Traumatic injury and pregnancy greater than 20 weeks gestation.
NECK AND THORACIC INJURIES	**NEUROLOGICAL INJURIES**
♦ Tracheobroncial tree injuries. ♦ Ruptured esophagus. ♦ Great vessel injury. ♦ Tension pneumothorax with respiratory failure. ♦ Major chest wall injury with more than two unilateral rib fractures. ♦ Bilateral rib fractures with pulmonary contusion ♦ Bilateral pulmonary contusions. ♦ Pneumothorax or hemothorax with respiratory failure. ♦ Wide mediastinum or other signs suggesting great vessel injury. ♦ Known or suspected cardiac injury. ♦ Penetrating injuries to the neck or chest.	♦ GCS less than 12 or lateralizing signs. ♦ GCS deteriorating by 2 during observation. ♦ Open or depressed skull fracture. ♦ Acute spinal cord injury. ♦ Spinal fractures, unstable or potentially unstable. ♦ Open spinal wounds. ♦ Penetrating injuries to the spine.
ABDOMINAL INJURIES	**PELVIC/UROGENITAL**
♦ Evisceration/open abdominal wound. ♦ Free air, fluid or solid organ injury on ultrasound FAST scan. ♦ Penetrating injuries to the abdomen.	♦ Pelvic ring disruption or unstable pelvic fracture. ♦ Traumatic amputations of the genitalia. ♦ Penetrating injuries to the pelvic cavity or retroperitoneal cavity,
EXTREMITY INJURIES	**BURN INJURIES**
♦ Amputation of extremity proximal to wrist or ankle. ♦ Open long-bone fractures. ♦ Two or more long bone fractures. ♦ Crush injury/mangled extremity. ♦ Fracture/dislocation with loss of distal pulses and/or ischemia. ♦ Vascular Injuries with active arterial bleeding.	♦ Second or third-degree thermal or chemical burns involving more than 10% of the total body surface area in patient under 15 years or over 55 years of age ♦ Second or third-degree thermal or chemical burns involving the face, eyes, ears, hands, feet, genitalia, perineum, and major joints. ♦ Third-degree burns greater than 5% of the body surface area in any age group. ♦ Electrical burns, including lightning injury.

LEMSA Medical Directors Group

- 8 LEMSA's, 17 counties
- Selective Spine Immobilization
- Saline lock
- Chest needle decompression
- START vs SALT triage

Selective Spine Immobilization Protocol



LEMSA Medical Directors Group

- 8 LEMSA's, 21 counties
- Selective Spine Immobilization
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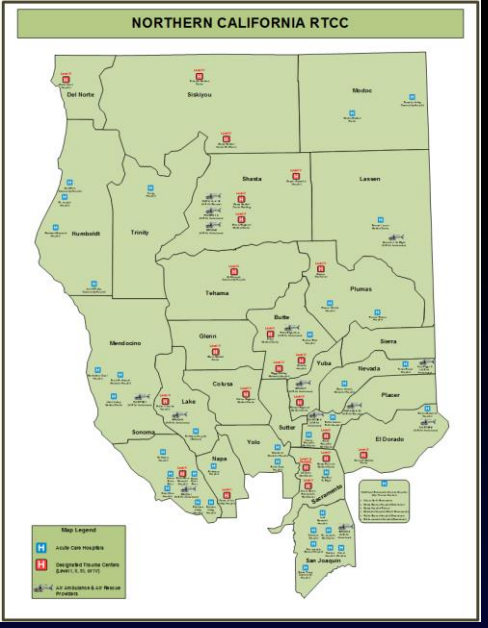
Intravenous Access Policy

1. Intravenous access shall be obtained for any patient who, upon clinical assessment, requires medication, fluids, or the potential need for urgent pharmaceutical intervention.
2. Unless the patient demonstrates evidence of hypovolemia or potential hypovolemia (trauma, dehydration, burns, spinal cord injury, sepsis), all IV catheters will be maintained with a saline lock.
3. Patients with evidence of hypovolemia (tachycardia, hypotension, or mechanism suggestive of internal volume loss) or potential hypovolemia will have intravenous fluid bags attached to their intravenous catheters.

Needle Decompression of Tension Pneumothorax

1. Tension pneumothorax should be suspected in patients with severe respiratory distress, who are hypotensive with a SBP <90 mmHg, AND with unilateral decreased breath sounds following a history of chest trauma.
2. Decompression of a tension pneumothorax should be immediately accomplished with insertion of a 3.25" 10 gauge chest decompression needle in the anterior axillary line at the 3rd to 4th intercostal space.
3. If anatomic variation precludes access to the anterior axillary line approach, decompression can be attempted by placing a needle on the affected side at the 2nd intercostal space, midclavicular line.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